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**HOSPITAL NAME**

**DOCTOR’S NOTE**

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor Name: |  | Designation: |  |
|  |  |  |  |  |  |
| Patient Name: |  | Age: |  | Gender: |  |

**To Whom It May Concern**

This is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been under my medical care for \_\_\_\_\_\_\_\_\_ days. Due to his/her disability, he/she is advised to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for a duration of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you need any additional information or clarification, please do not hesitate to contact us at the hospital number.

Sincerely,

[Doctor’s Name]

Medical License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_/\_\_/\_\_\_\_

123 Any Street, New York, USA

www.hospitalname.com

123-678-XXXX

**DOCTOR’S NOTE**

Hospital Name

Phone No.: 123-678-XXXX

Email: hospital@email.com

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor Name: |  | Designation: |  |
|  |  |  |  |  |  |
| Patient Name: |  | Age: |  | Gender: |  |

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Sincerely,

[Doctor’s Name]

Medical License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Doctor’s Sign]

Date: \_\_/\_\_/\_\_\_\_

Address: 123 Any Street, New York, USA

Website: www.hospitalname.com